OLGC Workcamp - Health Information Form

NAME: _____ DOB: _____ SSN: _____

Address: _____ Phone (h):(_____)_____

City: _____ State: _____ Zip: _____

Father's Name: _____ Work Phone: (_____)_____

Father's email: _____ Cell Phone: (_____)_____

Mother's Name: _____ Work Phone: (_____)_____

Mother's email: _____ Cell Phone: (_____)_____

Name of Person(s) having legal custody: _____

Child's Doctor: _____ Phone: (_____)_____

Known Allergies: Food: _____

Medicine: _____

Medications being taken: _____

Are your immunizations up to date? _____ Date of Last Tetanus: _____

Insurance company: _____ Policy #: _____

Policy holder's Name: _____ DOB: _____ SSN: _____

Relationship: _____ Insurance State or Federal: _____

Emergency Contacts: In the event a parent cannot be reached, give the name, address and phone number of two persons who to reach in a timely manner.

1) Name: _____ Phone(s): _____

Address: _____ Relationship: _____

2) Name: _____ Phone(s): _____

Address: _____ Relationship: _____

I hereby authorize OLGC Adult leaders to dispense the following over the counter medicines to my child:

_____ Tylenol _____ Ibuprofen _____ Benadryl _____ Aspirin _____ Neosporin

I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expense involved. I agree to indemnify the Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities.

_____ _____

Parent's Signature Date Parent's Signature Date